

DENTAL REGISTRY AND HISTORY

PATIENT INFORMATION

Date _____

Patient Name _____
Last Name _____
First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip _____

Sex M F

Birthdate _____ Age _____

Married Divorced Single Separated Widowed

Patient Employer _____

Occupation _____

Patient SS# _____

Spouse's Name _____

Phone Numbers (____) _____ (____) _____
Home# Cell Phone#

(____) _____ (____) _____
Work# Ext (Best time to reach you)

Who is responsible for this account? _____
Print name _____

Emergency Contact Information

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

Who may we thank for referring you? _____

A \$25 credit will be applied to your account per each referred family.

ARE YOU HAPPY WITH YOUR SMILE?

Are you happy with your smile? _____

Take a personal smile test:

A= Love it
B= Acceptable
C= Could be better
D= Don't like it
F= Don't like it at all
NP= Not a problem

Comments _____

Grade your smile

Whiteness _____

Staining/discoloration _____

Evenness of teeth _____

Chipping or Cracking _____

Existing dental work _____

Gum Health / Appearance _____

Smile line _____

DENTAL INSURANCE

Subscriber's Name _____

Insurance Co. _____

Group# _____

Relationship to Patient _____

Employer _____

Birthdate _____ SS# _____

I certify that I, and /or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of Patient, Parent, Guardian or Personal Representative _____

Please Print Name _____

Date _____

DENTAL HISTORY

Reason for today's visit _____

Date of last dental visit _____

Date of last dental X-rays _____

Please circle to indicate if you have had any of the following:

Bad breath	Pain around ear
Bleeding gums	Periodontal treatment
Blisters on lips or mouth	Sensitivity to cold
Burning sensation on tongue	Sensitivity to heat
Chew on one side of mouth	Sensitivity to sweets
Clicking or popping jaw	Sensitivity when biting
Dry Mouth	
Fingernail biting	
Food collection between the teeth	
Grinding teeth	
Gums swollen or tender	How often do you floss? _____
Jaw pain or tiredness	
Lip or cheek biting	How often do you brush _____
Loose teeth or broken fillings	
Mouth breathing	
Mouth pain, brushing	
Orthodontic treatment	
Sores or growth in your mouth	

HEALTH HISTORY

Physician's Name _____ Phone# _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combination of Ionimin, Adipex, Fastin (brand names of phentermine), Pandomin (fenfluramine) and Redux (dexfenfluramine). Y/N

Please circle Y/N to indicate if you have had any of the following:

AIDS/HIV	Y/N	Epilepsy	Y/N	Respiratory Disease	Y/N
Anemia	Y/N	Fainting or dizziness	Y/N	Rheumatic Fever	Y/N
Arthritis, Rheumatism	Y/N	Glaucoma	Y/N	Scarlet Fever	Y/N
Artificial Heart Valves	Y/N	Headaches	Y/N	Shortness of Breath	Y/N
Artificial Joints	Y/N	Heart Murmur	Y/N	Sinus Trouble	Y/N
Asthma	Y/N	Heart Problems	Y/N	Skin Rash	Y/N
Back Problems	Y/N	Hepatitis type _____	Y/N	Special Diet	Y/N
Bleeding abnormally, with extractions or surgery	Y/N	Herpes	Y/N	Stroke	Y/N
Blood disease	Y/N	High Blood Pressure	Y/N	Swollen Feet or Ankles	Y/N
Cancer	Y/N	Jaundice	Y/N	Swollen Neck Glands	Y/N
Chemical Dependancy	Y/N	Jaw Pain	Y/N	Thyroid Problems	Y/N
Chemotherapy	Y/N	Kidney Disease	Y/N	Tonsillitis	Y/N
Circulatory Problems	Y/N	Liver Disease	Y/N	Tuberculosis	Y/N
Congenital Heart Lesions	Y/N	Low Blood Pressure	Y/N	Tumor or growth on head or neck	Y/N
Cortisone Treatments	Y/N	Mitral Valve Prolapse	Y/N	Ulcer	Y/N
Cough, persistent or bloody	Y/N	Nervous Problems	Y/N	Venereal Disease	Y/N
Diabetes	Y/N	Pacemaker	Y/N	Weight Loss, unexplained	Y/N
Emphysema	Y/N	Psychiatric Care	Y/N	Any history of smoking	Y/N
		Radiation Treatment	Y/N		

Do you wear contact lenses? Y/N

Women:

Are you pregnant? Y/N Due date _____ Are you nursing? Y/N

Taking birth control pills? Y/N

MEDICATIONS

ALLERGIES

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone(____) _____

Y/N Aspirin
 Y/N Barbiturates (Sleeping pills)
 Y/N Codeine
 Y/N Iodine
 Y/N Latex
 Y/N Local Anesthetic
 Y/N Penicillin
 Y/N Sulfa
 Other _____

I affirm that information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Patient's or Parent's

Signature _____ Date _____ Doctor's Signature _____

MEDICAL HISTORY UPDATES

Date _____ Comments _____

Signature _____ Signature _____
 (Patient's) (Doctor's)

Date _____ Comments _____

Signature _____ Signature _____
 (Patient's) (Doctor's)